



Physician's Prescription – Statement of Medical Necessity

Patient's Name (Please Print)

Grid for Patient's Name

Email

Grid for Email

Prescription for OrthoCor Active Knee System with unlimited OrthoPod refills

*For limited number of OrthoPod Refills, check here [] Allow OrthoPod refills for _____ months.

Please specify the number of items to be ordered:

Table with 3 columns: Items to Order, Quantity, Unit Price. Rows include OrthoCor Active Knee System, OrthoPod Refills (15 treatments), and Shipping and Handling.

Sizing: Measure distance around center of knee in inches to determine sizing. Check correct size for patient.

Table for Sizing: Medium [], Large [], X-Large [] with corresponding height ranges: 16-18", 18-20", 20-22"

Clinic Name

Grid for Clinic Name

Phone _____ - _____ - _____

Clinic Address

Grid for Clinic Address

City _____ State _____ Zip _____

Name of Physician _____ Email _____

I the undersigned certify that the above equipment is medically necessary for this patient's being. In my opinion the equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient's condition.

Physician's Signature: X _____ Date Authorized: ____ / ____ / ____

TO BE FILLED OUT BY PATIENT (Please Print):

Referral Code:

Grid for Referral Code

Payment Info: Type [] VISA [] MC [] AMEX

Card Number _____ - _____ - _____

Exp Date ____ / ____ Security Code* _____ * 3 or 4 digit non-embossed number printed on front (AMEX) or back (VISA, MC) of card

Name on Card _____ Phone _____ - _____ - _____

NOTE: We do not ship to P.O. Boxes

Billing Address

Grid for Billing Address

City _____ State _____ Zip _____

[] Check box to ship to Billing Address

Shipping Address

Grid for Shipping Address

City _____ State _____ Zip _____

Card Holder's Signature: X _____

PLEASE FAX OR MAIL COMPLETED FORM TO ORTHOCOR MEDICAL

OrthoCor Medical, Inc.
80 South 8th Street Suite 4848
Minneapolis, MN 55402

Phone: 877-678-RELIEF (7354)
Fax: (888) 314-8870
Email: buy@orthocormedical.com

Confidential Health Form



This information will be used by OrthoCor Medical to help identify your specific clinical indications for use. OrthoCor is obligated to protect the privacy of individually identifiable health information in accordance with applicable laws.

Name _____ Date of Birth _____ Gender _____

Symptoms

These questions should be answered thinking of your knee symptoms during the **last week**.

S1. Do you have swelling in your knee?

Never Rarely Sometimes Often Always

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

Never Rarely Sometimes Often Always

S3. Does your knee catch or hang up when moving?

Never Rarely Sometimes Often Always

S4. Can you straighten your knee fully?

Never Rarely Sometimes Often Always

S5. Can you bend your knee fully?

Never Rarely Sometimes Often Always

Stiffness

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

S6. How severe is your knee joint stiffness after first wakening in the morning?

None Mild Moderate Severe Extreme

S7. How severe is your knee stiffness after sitting, lying or resting **later in the day**?

None Mild Moderate Severe Extreme

Pain

P1. How often do you experience knee pain?

Never Monthly Weekly Daily Always

What amount of knee pain have you experienced the **last week** during the following activities?

P2. Twisting/pivoting on your knee

None Mild Moderate Severe Extreme

P3. Straightening knee fully

None Mild Moderate Severe Extreme

Name _____ **Date of Birth** _____ **Gender** _____

P4. Bending knee fully

None Mild Moderate Severe Extreme

P5. Walking on flat surface

None Mild Moderate Severe Extreme

P6. Going up or down stairs

None Mild Moderate Severe Extreme

P7. At night while in bed

None Mild Moderate Severe Extreme

P8. Sitting or lying

None Mild Moderate Severe Extreme

P9. Standing upright

None Mild Moderate Severe Extreme

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself during the last week.

A1. Descending stairs

None Mild Moderate Severe Extreme

A2. Ascending stairs

None Mild Moderate Severe Extreme

A3. Rising from sitting

None Mild Moderate Severe Extreme

A4. Standing

None Mild Moderate Severe Extreme

A5. Bending to floor/pick up an object

None Mild Moderate Severe Extreme

A6. Walking on flat surface

None Mild Moderate Severe Extreme

A7. Getting in/out of car

None Mild Moderate Severe Extreme

Name _____ **Date of Birth** _____ **Gender** _____

A8. Going shopping

None Mild Moderate Severe Extreme

A9. Putting on socks/stockings

None Mild Moderate Severe Extreme

A10. Rising from bed

None Mild Moderate Severe Extreme

A11. Taking off socks/stockings

None Mild Moderate Severe Extreme

A12. Lying in bed (turning over, maintaining knee position)

None Mild Moderate Severe Extreme

A13. Getting in/out of bath

None Mild Moderate Severe Extreme

A14. Sitting

None Mild Moderate Severe Extreme

A15. Getting on/off toilet

None Mild Moderate Severe Extreme

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

Never Rarely Sometimes Often Always

A17. Light domestic duties (cooking, dusting, etc)

Never Rarely Sometimes Often Always

Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level during the last week.

SP1. Squatting

None Mild Moderate Severe Extreme

SP2. Running

None Mild Moderate Severe Extreme

SP3. Jumping

None Mild Moderate Severe Extreme

Name _____ Date of Birth _____ Gender _____

SP4. Twisting/pivoting on your injured knee

None Mild Moderate Severe Extreme

SP5. Kneeling

None Mild Moderate Severe Extreme

Quality of Life

Q1. How often are you aware of your knee problem?

Never Monthly Weekly Daily Constantly

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?

Not at all Mildly Moderately Severely Totally

Q3. How much are you troubled with lack of confidence in your knee?

Not at all Mildly Moderately Severely Extremely

Q4. In general, how much difficulty do you have with your knee?

None Mild Moderately Severe Extreme

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